MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

34171

File No. 9508

Registered No.

1. PLACE OF DEATH

County ..... Registration District No. .....

Township ..... Primary Registration District No. .....

City St Louis Mo. (No. Christian Hospital St. ..... Ward)

2. FULL NAME Faith Carroll

(a) Residence. No. 4932 Lilburn St., 7 Ward. (If nonresident, give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Female	White	Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 4 - 1930

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or 5 min.
	Premature	5 Mo. Gestation		

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) St Louis
(STATE OR COUNTRY) Mo.

PARENTS

10. NAME OF FATHER Jno P. Carroll.

11. BIRTHPLACE OF FATHER (CITY OR TOWN) St Louis
(STATE OR COUNTRY) Missouri.

12. MAIDEN NAME OF MOTHER Opal Delania Day.

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Missouri.

14. INFORMANT John P. Carroll.
(Address) 4932 Lilburn.

15. FILED OCT - 5 1930 19 Max C Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 4th 1930

17. I HEREBY CERTIFY, That I attended deceased from at birth 3.30 1930, to 3.35 AM, 1930 that I last saw her alive on Oct 4th, 1930, and that death occurred, on the date stated above, at 3.35 A.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
First one of triplet delivery premature, 5 mo gestation.

159 (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) 1610

(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH .....

DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) Aug Ellersieck, M. D.

, 19 (Address) #3505 N Jefferson,

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
New Pickers Cem.	Oct 6 1930
20. UNDERTAKER	ADDRESS
Provost Lund Co	3710 N. Grand,

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.